

		FOR BHF USE					

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH License ID Number: <u>0034678</u></p> <p>Facility Name: <u>THE LINCOLN HOME</u></p> <p>Address: <u>150 NORTH 27TH STREET</u> <u>BELLEVILLE</u> <u>62226</u> Number City Zip Code</p> <p>County: <u>SINCLAIR</u></p> <p>Telephone Number: <u>(618) 235-6600</u> Fax # <u>(618) 235-7555</u></p> <p>HFS ID Number: <u>37-1237031001</u></p> <p>Date of Initial License for Current Owners: <u>09/88</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2007</u> to <u>12/31/2007</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>MARTIN WEISS</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>PRESIDENT</u></td> </tr> <tr> <td rowspan="4" style="width: 15%;">Paid Preparer</td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u></td> </tr> <tr> <td>(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td> </tr> <tr> <td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> </tr> </table> <p align="right">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>MARTIN WEISS</u> (Date) _____		(Title) <u>PRESIDENT</u>	Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u>	(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>
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Facility Name & ID Number THE LINCOLN HOME

0034678 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	62	Skilled (SNF)	62	22,630	1
2		Skilled Pediatric (SNF/PED)			2
3	90	Intermediate (ICF)	90	32,850	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	152	TOTALS	152	55,480	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			5,750	5,750	8
9	SNF/PED					9
10	ICF	34,348	6,833		41,181	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	34,348	6,833	5,750	46,931	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.59%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 09/88

J. Was the facility purchased or leased after January 1, 1978?
YES Date 09/22 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 62 and days of care provided 5,750

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number

THE LINCOLN HOME

0034678

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	227,280	24,447	12,746	264,473		264,473		264,473		1
2	Food Purchase		221,921		221,921		221,921	(485)	221,436		2
3	Housekeeping	156,159	31,164		187,323		187,323		187,323		3
4	Laundry	71,753	21,920	4,938	98,611		98,611		98,611		4
5	Heat and Other Utilities			161,302	161,302		161,302		161,302		5
6	Maintenance	67,569	41,828	55,535	164,932		164,932	256	165,188		6
7	Other (specify):*			11,181	11,181		11,181		11,181		7
8	TOTAL General Services	522,761	341,280	245,702	1,109,743		1,109,743	(229)	1,109,514		8
	B. Health Care and Programs										
9	Medical Director			41,000	41,000		41,000		41,000		9
10	Nursing and Medical Records	1,887,396	141,884	12,609	2,041,889		2,041,889		2,041,889		10
10a	Therapy										10a
11	Activities	86,392	6,271	2,823	95,486		95,486		95,486		11
12	Social Services	56,036	1,354	2,338	59,728		59,728		59,728		12
13	CNA Training										13
14	Program Transportation			4,178	4,178		4,178		4,178		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,029,824	149,509	62,948	2,242,281		2,242,281		2,242,281		16
	C. General Administration										
17	Administrative	84,783		375,000	459,783		459,783	29	459,812		17
18	Directors Fees										18
19	Professional Services			388,591	388,591		388,591	(297,747)	90,844		19
20	Dues, Fees, Subscriptions & Promotions			98,652	98,652		98,652	(40,715)	57,937		20
21	Clerical & General Office Expenses	167,861	18,220	59,780	245,861		245,861	1,023	246,884		21
22	Employee Benefits & Payroll Taxes			506,370	506,370		506,370		506,370		22
23	Inservice Training & Education			17,719	17,719		17,719	126	17,845		23
24	Travel and Seminar			12,925	12,925		12,925	571	13,496		24
25	Other Admin. Staff Transportation			8,980	8,980		8,980		8,980		25
26	Insurance-Prop.Liab.Malpractice			133,763	133,763		133,763	14,501	148,264		26
27	Other (specify):*							28,617	28,617		27
28	TOTAL General Administration	252,644	18,220	1,601,780	1,872,644		1,872,644	(293,595)	1,579,049		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,805,229	509,009	1,910,430	5,224,668		5,224,668	(293,824)	4,930,844		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	10,262
	REPAIRS & MAINTENANCE	2,484
		0
		12,746
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	4,938
		0
		4,938
5	HEAT & OTHER UTILITIES	
	GAS HEAT	27,862
	ELECTRICITY	90,956
	WATER	41,107
	CABLE TV - LOBBY	1,377
		0
		161,302
6	MAINTENANCE	
	GROUNDS MAINTENANCE	6,666
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	1,305
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	40,384
	EXTERMINATING SERVICE	0
	FIRE SERVICE	7,180
		0
		0
		0
		0
		55,535
7	OTHER	
	SCAVENGER AND EXTERMINATING SERV	11,181
	SECURITY SERVICE	0
		0
		0
		11,181
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	41,000
		41,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,980
	PHARMACY CONSULTANT XVIII B 39-2	4,491
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	6,138
		0
		0
		12,609
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	2,823
		0
		2,823
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	2,338
	SOCIAL WORKER XVIII B 45-2	0
		0
		2,338
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	4,178
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	375,000
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	6,276
	ADMINISTRATIVE CONSULTANTS XIX C	300,000
	PROFESSIONAL FEES XIX C	82,315
		0
		388,591
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	37,444
	EMPLOYEE WANT ADS XIX F	42,452
	CONTRIBUTIONS VI 20 XIX F	1,000
	DUES & SUBSCRIPTIONS XIX F	9,391
	LICENSES & PERMITS XIX F	933
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	2,338
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,584
	PATIENT BACKGROUND CHECKS XIX F	3,510
		98,652
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	3,388
	EQUIPMENT REPAIR & MAINTENANCE	24,676
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	7,862
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	21,426
	MESSENGER SERVICE	2,428
		0
		59,780

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	214,291
	UNEMPLOYMENT COMPENSATION XIX D	77,099
	WORKERS COMPENSATION INSURANC XIX D	116,240
	HOSPITALIZATION INSURANCE XIX D	93,895
	EMPLOYEE BENEFITS - OTHER XIX D	4,845
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		506,370
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	17,719
		17,719
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	12,925
		12,925
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	8,980
		8,980
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	133,763
		133,763
27	OTHER	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

1,910,430

**THE LINCOLN HOME
SCHEDULES
12/31/2007**

**EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22**

TOTAL FOOD PURCHASE	221,921
LESS SALES TAX	<u>(485)</u>
NET FOOD	221,436

TOTAL PATIENT CENSUS	46,931
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	140,793

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	140,793
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	140,793

NET FOOD	221,436
DIVIDE TOTAL MEALS/YEAR	<u>140,793</u>

COST PER MEAL	1.57
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0

=====

Facility Name & ID Number

THE LINCOLN HOME

#0034678

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			33,267	33,267		33,267	160,296	193,563			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			36,576	36,576		36,576	240,696	277,272			32
33	Real Estate Taxes			2,530	2,530		2,530	47,388	49,918			33
34	Rent-Facility & Grounds			480,000	480,000		480,000	(468,337)	11,663			34
35	Rent-Equipment & Vehicles			8,512	8,512		8,512	11,821	20,333			35
36	Other (specify):*											36
37	TOTAL Ownership			560,885	560,885		560,885	(8,136)	552,749			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		189,966	558,928	748,894		748,894		748,894			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			83,220	83,220		83,220		83,220			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		189,966	642,148	832,114		832,114		832,114			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,805,229	698,975	3,113,463	6,617,667		6,617,667	(301,960)	6,315,707			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number **THE LINCOLN HOME**

0034678

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(33,272)	30		9
10	Interest and Other Investment Income	(9,426)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(485)	2		13
14	Non-Care Related Interest	(48)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(7,862)	21		18
19	Entertainment		20		19
20	Contributions	(3,338)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(37,444)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (91,875)		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(210,085)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (210,085)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (301,960)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

THE LINCOLN HOME

ID# 0034678

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	DEFERRED MAINTENANCE	\$ 0	6
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number THE LINCOLN HOME

0034678

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(485)	0	0	0	0	0	0	0	0	0	0	(485)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	256	0	0	0	0	0	0	0	0	256	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(485)	0	256	0	(229)	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	29	0	0	0	0	0	0	0	0	29	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,250	(298,997)	0	0	0	0	0	0	0	0	(297,747)	19
20	Fees, Subscriptions & Promotions	(40,782)	0	67	0	0	0	0	0	0	0	0	(40,715)	20
21	Clerical & General Office Expenses	(7,862)	0	8,885	0	0	0	0	0	0	0	0	1,023	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	126	0	0	0	0	0	0	0	0	126	23
24	Travel and Seminar	0	0	571	0	0	0	0	0	0	0	0	571	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	14,501	0	0	0	0	0	0	0	0	0	14,501	26
27	Other (specify):*	0	0	28,617	0	0	0	0	0	0	0	0	28,617	27
28	TOTAL General Administration	(48,644)	15,751	(260,702)	0	(293,595)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(49,129)	15,751	(260,446)	0	(293,824)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number THE LINCOLN HOME

0034678

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(33,272)	193,568	0	0	0	0	0	0	0	0	0	160,296	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,474)	250,170	0	0	0	0	0	0	0	0	0	240,696	32
33	Real Estate Taxes	0	47,388	0	0	0	0	0	0	0	0	0	47,388	33
34	Rent-Facility & Grounds	0	(480,000)	11,663	0	0	0	0	0	0	0	0	(468,337)	34
35	Rent-Equipment & Vehicles	0	0	11,821	0	0	0	0	0	0	0	0	11,821	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(42,746)	11,126	23,484	0	(8,136)	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(91,875)	26,877	(236,962)	0	(301,960)	45							

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		ATRIUM HEALTH CARE & REHABILITATION		WEISS MGMT.		
		CENTER OF CAHOKIA, LLC	CAHOKIA	GROUP, INC.	SKOKIE	MGMT/CLERICAL
SEE ATTACHED SCHEDULE						
				LINCOLN		
				ASSOC., L.P.	SKOKIE	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 RENT	\$ 480,000	LINCOLN ASSOCIATES, L.P.	100.00%	\$	(480,000)	1
2	V	30 DEPRECIATION		" "		193,568	193,568	2
3	V	32 INTEREST EXPENSE		" "		228,335	228,335	3
4	V	33 REAL ESTATE TAXES		" "		47,388	47,388	4
5	V	32 MORTGAGE INSURANCE		" "		21,835	21,835	5
6	V	19 PROFESSIONAL FEES		" "		1,250	1,250	6
7	V	26 INSURANCE		" "		14,501	14,501	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 480,000			\$ 506,877	\$ * 26,877	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 MANAGEMENT FEES	\$ 375,000	WEISS MANAGEMENT GROUP, INC.	100.00%	\$	\$ (375,000)
16	V	19 BOOKKEEPING/ADMINIST.SERV	300,000	" " " "			(300,000)
17	V						
18	V						
19	V	6 REPAIRS/MAINTENANCE		" " " "		256	256
20	V	17 ADMINISTRATIVE SALARIES		" " " "		375,029	375,029
21	V	19 PROFESSIONAL FEES		" " " "		1,003	1,003
22	V	20 LICENCE AND PERMITS		" " " "		67	67
23	V	21 OFFICE EXPENSES		" " " "		8,885	8,885
24	V	23 SEMINARS		" " " "		126	126
25	V	24 TRAVEL		" " " "		571	571
26	V	27 EMPLOYEE BENEFITS		" " " "		28,617	28,617
27	V	34 OFFICE RENT		" " " "		11,663	11,663
28	V	35 EQUIPMENT RENT		" " " "		11,821	11,821
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 675,000			\$ 438,038	\$ * (236,962)

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number

THE LINCOLN HOME

0034678

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2	MARTIN WEISS	PRESIDENT	ADMINISTR.	45.10	SEE ATTACHED SCHEDULE	20		SALARY	150,012	17-7	2
3											3
4											4
5	DANIEL WEISS	MANAGER	MANAGEMENT	12.31		12		SALARY	90,007	17-7	5
6											6
7	NATAN WEISS	CONTROLLER	BOOKKEEPING	8.39		18		SALARY	135,010	17-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 375,029		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number THE LINCOLN HOME

0034678 Report Period Beginning: 01/01/2007 Ending: 2/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization WEISS MANAGEMENT GROUP, INC
 Street Address 3856 OAKTON STREET
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847) 933-9200
 Fax Number (847) 933-9765

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	REPAIRS/MAINTENANCE	PATIENT CENSUS	83880	2	\$ 457	\$ 46,931	\$ 256	1
2	17	ADMINISTRATIVE SALARIES	PATIENT CENSUS	83880	2	670,291	46,931	375,029	2
3	19	PROFESSIONAL FEES	PATIENT CENSUS	83880	2	1,792	46,931	1,003	3
4	20	LICENCE AND PERMITS	PATIENT CENSUS	83880	2	120	46,931	67	4
5	21	OFFICE EXPENSES	PATIENT CENSUS	83880	2	15,880	46,931	8,885	5
6	23	SEMINARS	PATIENT CENSUS	83880	2	225	46,931	126	6
7	24	TRAVEL	PATIENT CENSUS	83880	2	1,020	46,931	571	7
8	27	EMPLOYEE BENEFITS	PATIENT CENSUS	83880	2	51,147	46,931	28,617	8
9	34	OFFICE RENT	PATIENT CENSUS	83880	2	20,845	46,931	11,663	9
10	35	EQUIPMENT RENT	PATIENT CENSUS	83880	2	21,128	46,931	11,821	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 782,905	\$ 670,291	\$ 438,038	25

Facility Name & ID Number

THE LINCOLN HOME

0034678

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	RELATED PARTY: THE LIMCOLN ASSOCIATION, LLC						\$	\$			\$	1						
2	CAMBRIDGE REALTY		X	MORTGAGE	\$31,065.72	04/04	4,528,900	4,342,247	04/39	5.1400	224,951	2						
3	LOAN COSTS		X	LOAN COSTS	W/O OVER COSTS		118,455	105,765			3,384	3						
4	MIP INSURANCE										21,835	4						
5												5						
Working Capital																		
6	BANK FINANCIAN		X	WORKING CAPITAL	DEMAND			697,310		PRIME+	36,528	6						
7												7						
8												8						
9	TOTAL Facility Related				\$31,065.72		\$ 4,647,355	\$ 5,145,322			\$ 286,698	9						
B. Non-Facility Related*																		
10	IRS, IDR, ETC		X	LATE FEES							48	10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ 48	14						
15	TOTALS (line 9+line14)						\$ 4,647,355	\$ 5,145,322			\$ 286,746	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 21,835 Line # 32-7

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2006 report.		\$	44,310	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	47,114	2
3. Under or (over) accrual (line 2 minus line 1).		\$	2,804	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	47,114	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	49,918	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	25,689	8
	2003	29,752	9
	2004	37,967	10
	2005	44,310	11
	2006	47,114	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2006	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

THE PAYMENT ON LINE 2 APPLIES TO THE 2006 TAX BILL.

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME THE LINCOLN HOME COUNTY SINCLAIR

FACILITY IDPH LICENSE NUMBER 0034678

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>08-20.0-204-015</u>	<u>NURSING HOME</u>	\$ <u>2,530.40</u>	\$ <u>2,530.40</u>
2. <u>08-20.0-210-029</u>	<u>NURSING HOME</u>	\$ <u>43,515.66</u>	\$ <u>43,515.66</u>
3. <u>08-20.0-207-025</u>	<u>NURSING HOME</u>	\$ <u>798.30</u>	\$ <u>798.30</u>
4. <u>08-20.0-210-028</u>	<u>NURSING HOME</u>	\$ <u>269.76</u>	\$ <u>269.76</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>47,114.12</u>	\$ <u>47,114.12</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number THE LINCOLN HOME

0034678

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,241 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 2

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>NURSING HOME</u>			\$ <u>148,649</u>	<u>1</u>
2	<u>PARKING LOT</u>		<u>2005</u>	<u>50,000</u>	<u>2</u>
3	TOTALS			\$ <u>198,649</u>	<u>3</u>

Facility Name & ID Number THE LINCOLN HOME

0034678

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	152	1988		\$ 2,011,351	\$ 63,852	31.5	\$ 63,852	\$	\$ 1,206,281	4
5		2003		1,249,221	45,426	27.5	45,426		202,524	5
6										6
7										7
8										8
	Improvement Type**									
9	VARIOUS		1990	11,158	354	31.5	354		6,112	9
10	VARIOUS		1993	6,676	171	39	171		3,266	10
11	VARIOUS		1994	7,797	200	39	200		3,658	11
12	VARIOUS		1995	13,072	335	39	335		5,252	12
13	CARPET		1996	907	23	39	23		305	13
14	BILLBOARD		1996	900	23	39	23		308	14
15	SMOKE DETECTORS		1996	602	15	39	15		205	15
16	PARKING LOT		1996	8,006	205	39	205		2,845	16
17	AWNING		1996	905	23	39	23		323	17
18	CARPETING		1996	1,512	39	39	39		560	18
19	DOOR LOCKS		1997	2,100	54	39	54		652	19
20	WALL PAPER		1997	2,012	52	39	52		638	20
21	HANDRAIL		1997	3,217	83	39	83		942	21
22	FIRE ALARM SYSTEM		1998	11,636	298	39	298		2,973	22
23	WALLPAPER & HANDRAILS FOR NURSING STATION		1998	9,227	236	39	236		2,361	23
24	PAINTING/WALLPAPERING		1998	2,988	77	39	77		768	24
25	REPLACE PVC PIPE IN BASEMENT		1998	1,074	28	39	28		279	25
26	WALLPAPER, HANDRAILS, CRASHRAILS, CORNER GUARD		1999	6,144	158	39	158		1,032	26
27	INSTALLED A NEW DURO-LAST ROOF		1999	56,400	1,446	39	1,446		9,394	27
28	WALLPAPER		2000	14,896	382	39	382		3,419	28
29	SEWER LINE REPAIR		2000	11,743	301	39	301		2,251	29
30	AIR CONDITIONING UNITS		2000	8,848	227	39	227		1,697	30
31	CONDENSING UNIT ON FREEZER		2000	2,693	69	39	69		519	31
32	NEW NURSES STATION		2000	20,379	522	39	522		3,925	32
33	FIRE ALARM SYSTEM		2000	1,826	47	39	47		353	33
34	HOT WATER SYSTEM		2000	3,849	99	20	99		1,757	34
35	TILED FLOORS		2000	54,185	1,389	39	1,389		10,427	35
36	REMODELING OF BATHROOMS		2000	18,490	474	39	474		3,553	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number THE LINCOLN HOME

0034678

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	INSTALLED A/C UNITS FOR RESIDENT ROOMS	2000	\$ 13,369	\$ 726	20	\$ 668	\$ (58)	\$ 7,334	37
38	WALLPAPERING, FLOORING,CARPENTING	2001	35,921	1,306	27.5	1,306		8,490	38
39	ROOF	2001	47,500	1,727	27.5	1,727		11,226	39
40	AIR CONDITIONERS,HEATERS, SPEAKERS	2001	9,154	334	27.5	334		2,170	40
41	ELECTRICAL WORK	2001	12,200	444	27.5	444		2,886	41
42	RECEPTION STATION	2001	11,356	413	27.5	413		2,684	42
43	WINDOW TREATMENTS, CUBICLE TRACK,DOORS	2001	54,533	1,983	27.5	1,983		12,889	43
44	EXTENSIVE WORK	2001	37,603	1,366	27.5	1,366		8,880	44
45	RESIDENT ROOMS-PAINTING, CLOSET, CORRID. DOORS	2002	31,159	2,346	20	1,558	(788)	9,348	45
46	RENOVATIONS TO THE SHOWER & STORAGE ROOM	2002	6,853	249	27.5	249		1,422	46
47	INSTALLATION OF THE NEW GENERATOR SET CONTROL	2002	17,036	619	27.5	619		3,534	47
48	INSTALL STEP RAILS FOR SIDEWALK AREA, FRONT ENTI	2002	7,245	263	27.5	263		1,501	48
49	LANDSCAPING	2004	7,759	1,551	15	517	(1,034)	1,745	49
50	REPLACEMENT WINDOWS	2004	32,853	6,571	20	1,643	(4,928)	6,572	50
51	INSTALL CONCRETE DUMSTER PAD AND DRIVE	2004	6,270	1,254	20	314	(940)	1,256	51
52	REMODELING SHOWER ROOM-FLOOR &WALL CERAMIC	2004	105,250	21,050	20	5,263	(15,787)	21,052	52
53	WALL AIR CONDITIONS	2005	3,190	116	27.5	116		285	53
54	FLOORING, WALLCOVERING-2 RESTROOMS	2005	2,528	92	27.5	92		226	54
55	FURNISH AND INSTALL FIRE RATED DOORS & FRAMES	2005	30,429	1,106	27.5	1,106		2,720	55
56	EXCAVATING AND POURING CONCRETE SIDEWALKS	2005	9,450	344	27.5	344		845	56
57	INSTALL RAILS, REPLACEMENT WINDOWS	2005	8,406	306	27.5	306		752	57
58	INSTALL ALARM SYSTEM	2005	39,496	1,436	27.5	1,436		3,530	58
59	NURSE CALL SYSTEM	2005	18,665	679	27.5	679		1,669	59
60	LOBBY AREA, VESTIBULE-FLOORING	2006	17,906	3,581	5	3,581		5,372	60
61	AIR CONDITIONERS	2007	7,968	1,594	5	1,594		1,594	61
62	RESIDENT ROOMS - HINGET DOORS-NO CROWN	2007	57,309	1,129	27.5	1,129		1,129	62
63	PARKING LOT AND FENCE	2007	5,125	85	15	85		85	63
64	REPLACED 3 COMPRESSORS IN RTU'S	2007	3,914	65	27.5	65		65	64
65	PAINTING	2007	9,986	1,997	5	1,997		1,997	65
66	GARDEN	2007	60,172	1,671	15	1,671		1,671	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,254,419	\$ 173,011		\$ 149,476	\$ (23,535)	\$ 1,603,508	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 67,455	\$ 15,062	\$ 7,475	\$ (7,587)	3-10	\$ 19,945	71
72	Current Year Purchases	18,256	3,488	1,006	(2,482)	5-10	1,006	72
73	Fully Depreciated Assets	89,692					89,692	73
74	RELATED PARTY		27,306	27,306				74
75	TOTALS	\$ 175,403	\$ 45,856	\$ 35,787	\$ (10,069)		\$ 110,643	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	2005 FORD ECONOLINE	2005	\$ 41,500	\$ 7,968	\$ 8,300	\$ 332	5	\$ 24,900	76
77										77
78										78
79										79
80	TOTALS			\$ 41,500	\$ 7,968	\$ 8,300	\$ 332		\$ 24,900	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,669,971	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 226,835	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 193,563	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (33,272)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,739,051	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ \$ 8512 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18			N/A		18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____ /2008 \$ _____

13. _____ /2009 \$ _____

14. _____ /2010 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
<p>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>		

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 246,154	\$		\$ 246,154	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			66,282			66,282	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			246,492			246,492	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts			149,423			149,423	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	RADIOLOGY, LAB Other (specify): MEDICAL SUPPLIES	39-2 39-2				29,485 11,058			29,485 11,058	13
14	TOTAL			\$		\$ 748,894	\$		\$ 748,894	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number THE LINCOLN HOME

0034678

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 125,670	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,635,894		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	46,351		6
7	Other Prepaid Expenses	23,660		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,831,575	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	124,026		13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	150,192		15
16	Equipment, at Historical Cost	216,902		16
17	Accumulated Depreciation (book methods)	(174,356)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 316,764	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,148,339	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 503,261	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,281,877		29
30	Accrued Salaries Payable	93,813		30
31	Accrued Taxes Payable (excluding real estate taxes)	13,041		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,891,992	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,891,992	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 256,347	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,148,339	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 69,294	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 69,294	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	187,053	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 187,053	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 256,347	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,512,805	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,512,805	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	282,489	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 282,489	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	9,426	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 9,426	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,804,720	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,109,743	31
32	Health Care	2,242,281	32
33	General Administration	1,872,644	33
	B. Capital Expense		
34	Ownership	560,885	34
	C. Ancillary Expense		
35	Special Cost Centers	748,894	35
36	Provider Participation Fee	83,220	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,617,667	40
41	Income before Income Taxes (line 30 minus line 40)**	187,053	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 187,053	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number THE LINCOLN HOME

0034678

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,017	2,081	\$ 76,193	\$ 36.61	1
2	Assistant Director of Nursing	4,103	4,175	90,903	21.77	2
3	Registered Nurses	4,643	4,797	120,318	25.08	3
4	Licensed Practical Nurses	28,896	30,315	591,626	19.52	4
5	CNAs & Orderlies	90,072	92,411	891,033	9.64	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	8,730	8,991	86,392	9.61	10
11	Social Service Workers	4,541	4,818	56,036	11.63	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	26,185	27,253	227,280	8.34	15
16	Dishwashers					16
17	Maintenance Workers	4,000	4,160	67,569	16.24	17
18	Housekeepers	17,641	18,600	156,159	8.40	18
19	Laundry	9,724	10,049	71,753	7.14	19
20	Administrator	1,954	2,107	84,783	40.24	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,990	12,788	167,861	13.13	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)	5,393	5,676	117,323	20.67	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	219,889	228,221	\$ 2,805,229 *	\$ 12.29	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	M	\$ 10,262	1-3	35
36	Medical Director	O	41,000	9-3	36
37	Medical Records Consultant	N	1,980	10-3	37
38	Nurse Consultant	T	6,138	10-3	38
39	Pharmacist Consultant	H	4,491	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	2,823	11-3	44
45	Social Service Consultant	E	2,338	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 69,032		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses		N/A	10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number THE LINCOLN HOME

0034678

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
WOLFGANG VOLZ	ADMINISTRATOR	0	\$ 84,783	Workers' Compensation Insurance	\$ 116,240	IDPH License Fee	\$	
				Unemployment Compensation Insurance	77,099	Advertising: Employee Recruitment	42,452	
				FICA Taxes	214,291	Health Care Worker Background Check	1,584	
				Employee Health Insurance	93,895	(Indicate # of checks performed 158)		
				Employee Meals	0	Patient Background Checks	351	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	3,338	
				EMPLOYEE BENEFITS - OTHER	4,845	MARKETING/ADV/PROMO	37,444	
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	10,324	
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOC	67	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(3,338)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(37,444)	
						Yellow page advertising	(0)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 84,783	TOTAL (agree to Schedule V, line 22, col.8)	\$ 506,370	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 57,937	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
WEISS MANAGEMENT GROUP	MANAGEMENT FEES		\$ 375,000				Out-of-State Travel	\$
							In-State Travel	12,925
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 375,000				MGMT CO ALLOC	571
C. Professional Services								
Vendor/Payee	Type		Amount					
ALPHA DATA SERVICE	DATA PROCESSING		\$ 6,276				Seminar Expense	0
KRUPNICK,BOKOR,KAGDA	ACCOUNTING		10,550					
GARY WEINTRAUB. P.C.	LEGAL FEES		24,525				Entertainment Expense	()
LANER MUCHIN	LEGAL FEES		6,406					
HEPLER,BROOM,MACDONALD	LEGAL FEES		25,327				TOTAL (agree to Sch. V, line 24, col. 8)	\$ 13,496
MPRO	PROFESSIONAL REVIEWER		1,160					
WEISS MANAGEMENT GROUP	BOOKKEEP./ADM.SERV		300,000					
RICHARD PEELO & ASSOC	MEDICARE CONSULTANT		4,500					
SHARON HAUGH	MEDICARE CONSULTANT		3,000					
PERSONNEL PLANNERS	UC CONSULTANT		6,847					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 388,591	TOTAL				

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number THE LINCOLN HOME

0034678

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL ON LONG TERM CARE \$ 6682
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 83,220
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. **Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees